



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF PLANO
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name

Indemnity Insurance Company of North America

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-3855-01

MFDR Date Received

July 6, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit you have not paid what we determine as a amount for these inpatient services."

Amount in Dispute: \$331.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Carrier acknowledged receipt of medical fee dispute notice however, no notice submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 10, 2010	Outpatient Hospital Services	\$331.24	\$331.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 23, 2010

- 59 – (59) PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- BL – TO AVOID DUPLICATE BILL DENIAL. FOR ALL RECON/ADJUSTMENTS/ADDITIONAL. PYMNT

REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

EXPLANATION OF BENEFITS DATED APRIL 26, 2011

- 59 – (59) PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL

EXPLANATION OF BENEFITS DATED JUNE 13, 2011

- BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL
- BL – ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS CLAIM WAS PAID IN ACCORDANCE WITH STATE GUIDELINES, USUAL/CUSTOMARY POLICIES, OR TH
- BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR CLEAR NOTATION THAT
- W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- 59 – (59) PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
- W1 – (W1) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL.
- 59 – (59) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables if applicable. Review of the submitted documentation finds that separate reimbursement for implantables not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 72020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.94. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$26.22. The non-labor related portion is 40% of the APC rate or \$17.96. The sum of the labor and non-labor related amounts is \$44.18. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this line is \$44.18. This amount multiplied by 200% yields a MAR of \$88.36.
 - Procedure code 73610 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.94. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$26.22. The non-labor related portion is 40% of the APC rate or \$17.96. The sum of the labor and non-labor related amounts is \$44.18. The cost of these services does not exceed the annual

fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this line is \$44.18. This amount multiplied by 200% yields a MAR of \$88.36.

- Procedure code 99285 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If OPPS criteria are met, this service is assigned to composite APC. Composite criteria are not met. These services are classified under APC 0616, which, per OPPS Addendum A, has a payment rate of \$329.73. This amount multiplied by 60% yields an unadjusted labor-related amount of \$197.84. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$192.52. The non-labor related portion is 40% of the APC rate or \$131.89. The sum of the labor and non-labor related amounts is \$324.41. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this line is \$324.41. This amount multiplied by 200% yields a MAR of \$648.82.
 - Procedure code 99205 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If OPPS criteria are met, this service is assigned to composite APC. Composite criteria are not met. These services are classified under APC 0608, which, per OPPS Addendum A, has a payment rate of \$167.52. This amount multiplied by 60% yields an unadjusted labor-related amount of \$100.51. This amount multiplied by the annual wage index for this facility of 0.9731 yields an adjusted labor-related amount of \$97.81. The non-labor related portion is 40% of the APC rate or \$67.01. The sum of the labor and non-labor related amounts is \$164.82. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this line is \$164.82. This amount multiplied by 200% yields a MAR of \$329.64.
3. The total allowable reimbursement for the services in dispute is \$1,155.18. The amount previously paid by the insurance carrier is \$823.48. The requestor is seeking additional reimbursement in the amount of \$331.24. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$331.24.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$331.24, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 8, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.